

379105

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 31893

1- FOR  
STATE  
REGISTRAR

REG. NO.

DECEASED NAME FIRST MIDDLE LAST 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
(TYPE OR PRINT) Beatrice Henry Brown Nov. 27, 1985 12:00 PM

3 SEX 4 RACE 5. DATE OF BIRTH 6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS  
Female Black April 15, 1908 87 YRS MONTH DAY YEAR MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH  
Maryland USA Kent MD.

10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY  
Chestertown At Home Labor

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS / ZIP CODE  
Maryland Kent Chestertown YES ☐ NO ☒ R.F.D. 4 21620

14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
George Thomas Henry Germaine Resin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS  
NO 213-22-7975 Mrs. Germaine Brown Chestertown Md. CLARKSON R.F.D. #

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cerebral vascular accident  
DUE TO, OR AS A CONSEQUENCE OF  
(b) arteriosclerotic cardio vascular disease  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐ YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY 21f. LOCATION CITY OR TOWN COUNTY STATE  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) STREET

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE 22c. DATE SIGNED  
Robert W. Farr M.D. DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS  
Robert W. Farr M.D. Chestertown, Maryland 21620

23a. BURIAL, CREMATION, REMOVAL 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE  
Burial Nov. 30, 85 Asbury Cemetery Chestertown Kent, Md.

24. FUNERAL DIRECTOR: NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
Zenith Wall Chestertown, Md. DEC 3 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



379136

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 1 8 9 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sarah NMN Burke</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/26/85</b>                                       |  | 2b. HOUR<br><b>12:10 PM</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 27 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Kent</b> MD.                                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Chestertown</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kent &amp; Queen Anne's Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Quality Court Sec</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Campbell's Sew</b>                                 |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b> |  |   | 13b. COUNTY<br><b>KENT</b>   | 13c. CITY OR TOWN<br><b>WORTON</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LESTER MERRITT CARTER</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RACHEL (NMN) WOOD</b>                    |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-36-7484</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>HOLLY B. BOHLINGER 4534 VAN NESS ST. NW WASHINGTON D.C.</b> |   |

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><i>Patrick Moloney</i>  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/24/85</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICK MOLONEY</b>   | 22e. ADDRESS<br><b>CHESTERTOWN MD. 21620</b>   |  |  |

|  |                              |  |  |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b> | 23b. DATE<br><b>11/27/85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SILVERBROOK CREM.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WILMINGTON DEL.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marvin V. Waller</b>          |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 02 1985</b>            | 25b. REGISTRAR'S SIGNATURE<br><i>John H. ...</i>                     |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CHRISTIANITY AND A GOOD ANNE'S MEDICAL

11:00 AM

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336022

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ada Florence Fischer   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>11 22 85 |  |  | 2b HOUR<br>8:21<br>A M  |  |   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>white  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 25, 1910  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75<br>YRS.  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Chestertown  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Kent MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Chestertown   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kent & Queen Anne's Hospital Inc |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home maker & School Bus Driver |  | 12b KIND OF BUSINESS OR INDUSTRY<br>School Bus  |  |
| 13a STATE<br>Md.  |  | 13b COUNTY<br>Kent   |  | 13c CITY OR TOWN<br>Chestertown  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 13e STREET ADDRESS / ZIP CODE<br>RFD Tolchester 21620   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>George W. Hayes  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Kindell   |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17 INFORMANT<br>RFD Tolchester 21620<br>Edwin Hayes Chestertown, Md.   |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary Edema</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Dissecting Aneurysm + Multiple MI</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>   |  |  |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>11/22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |   |  |
| 22b SIGNATURE<br><u>M. R. Wynn</u>  |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  | 22c DATE SIGNED   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>KIN KUE WUN   |  |  |  | 22e ADDRESS<br>216 High St. Chestertown, Md. 21620   |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b DATE<br>11/25/85   |  | 23c NAME OF CEMETERY OR CREMATORY<br>St. Paul's Cemetery   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>near Chestertown, Md.                                |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>Willis Wells</u>  |  |  |  | ADDRESS<br>Chestertown, Md.  |  | 25a NO. OF COPIES REGISTERED<br>NOV 27 1985   |  | 25b REGISTRAR'S SIGNATURE<br><u>John Davidson-Rendell</u>   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

33003



RECEIVED NOV 20 1964

11

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

336099

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 1 8 9 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                    |  |  |  |  |                     |  |  |  |   |  |
|--|--|---|--|---|--------------------|--|--|--|--|---------------------|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SAMUEL LOUIS GRAVES JR.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 17, 1985 |   | 2b. HOUR<br>9:30pm |  |  |  |  |                     |  |  |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>NEGRO  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 29, 1917   |                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68<br>YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 8. IF UNDER 24 HRS. |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>KENT CO. MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                   |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>KENT MD.                                     |  |  |  |                     |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>CHESTERTOWN   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MD RT 289 QUAKER NECK RD (at home) |  |   |                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>TAILOR            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING  |  |                     |  |  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS AND (MISSION))<br>STATE<br>MARYLAND  |  |   |  | 13b. COUNTY<br>KENT   |                    | 13c. CITY OR TOWN<br>CHESTERTOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |                     |  | 13e. STREET ADDRESS / ZIP CODE<br>RT 3 BOX 85 QUAKER NECK RD 21620 |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL LOUIS GRAVES JR.  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>DELMAR LINDSAY   |                    |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(O OR UNKNOWN)<br>NO   |  |                     |  | 16b. SOCIAL SECURITY NO.<br>220-09-1020                            |  | 17. INFORMANT<br>ADDRESS<br>CHESTERTOWN 21620<br>MARY JOHNSON sister QUAKER NECK RD |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Ca Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 hrs</u> |  |   |  |   |                    |  |  |  |  |                     |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.   |  |   |  |   |                    |  |  |  |  |                     |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                     |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                    |  |  |  |  |                     |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                    |  |  |  |  |                     |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> 19 <u>73</u> to <u>10/17</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10/10</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                    |  |  |  |  |                     |  |  |  |   |  |
| 22b. SIGNATURE<br><u>C. Gottfried Baumann</u>  |  |   |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                    |  |  | 22c. DATE SIGNED<br><u>11/20/85</u>  |  |                     |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. C. GOTTFRIED BAUMANN  |  |   |  | 22e. ADDRESS<br>21620 MEDICAL OFFICE BLDG CHESTERTOWN MD  |                    |  |  |  |  |                     |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>Nov. 20, 1985  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>EMMANUEL METH.  |                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>POMONA, KENT, MARYLAND                 |  |  |  |                     |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FELLOWS F.H. BOX 270 MILLINGTON, MD 21651  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |                    | 25b. REGISTRAR'S SIGNATURE<br><u>Nov 26 1985</u>                                     |  |  |  |                     |  |  |  |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked on item 18, sign any injury, or other traumatic event, the medical examiner may be required to examine the body.

BP



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319093

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

BETTY JANE PINSON

2a. DATE KNOWN OF DEATH  
ESTIMATED Nov. 9 19857b. HOUR  
5:00 PM3. SEX  
female4. RACE  
white5. DATE OF BIRTH  
MONTH DAY YEAR  
12/29/19266. AGE (IN YEARS  
LAST BIRTHDAY)  
858 YRS.IF UNDER 1 YR.  
MONTHS DAYSIF UNDER 24 HRS.  
HOURS MIN.2c. DATE PRONOUNCED DEAD  
Nov. 7 19852d. HOUR  
11:00 AM7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Penna.7b. CITIZEN OF WHAT COUNTRY?  
USA8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH  
Kent

MD

10. CITY OR TOWN OF DEATH  
Rock Hall11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Stoops Trailer Park12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Nurse's Aid12b. KIND OF BUSINESS OR INDUSTRY  
Private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Md.13b. COUNTY  
Kent13c. CITY OR TOWN  
Rock Hall13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐13e. STREET ADDRESS  
P.O. Box. 21661  
Stoops Trailer Park14. FATHER'S NAME  
FIRST MIDDLE LAST

Joseph Bordley

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST

Mildred Minshall

St

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
no16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)  
202 18 868317. INFORMANT  
ADDRESS 28 East 22nd.  
Linda Bordley Chester Pa. 19013

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Robert W. Farr

M.D.

Deputy

MEDICAL EXAMINER

DATE SIGNED

11/7/85

EXAMINER'S NAME  
(TYPE OR PRINT)

Chestertown, Kent Co., Maryland 21620

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

11/11/85

23c. NAME OF CEMETERY OR CREMATORY

Glenwood Memorial

23d. LOCATION  
CITY OR TOWN

Marple Dela. Co. Pa.

COUNTY STATE

24. FUNERAL DIRECTOR

J. Wells Wells

ADDRESS

Chestertown, Md.

25a. DATE REC'D. BY REGISTRAR

NOV 12 1985

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN FORM 1. 2. AND 3. TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. 2. AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

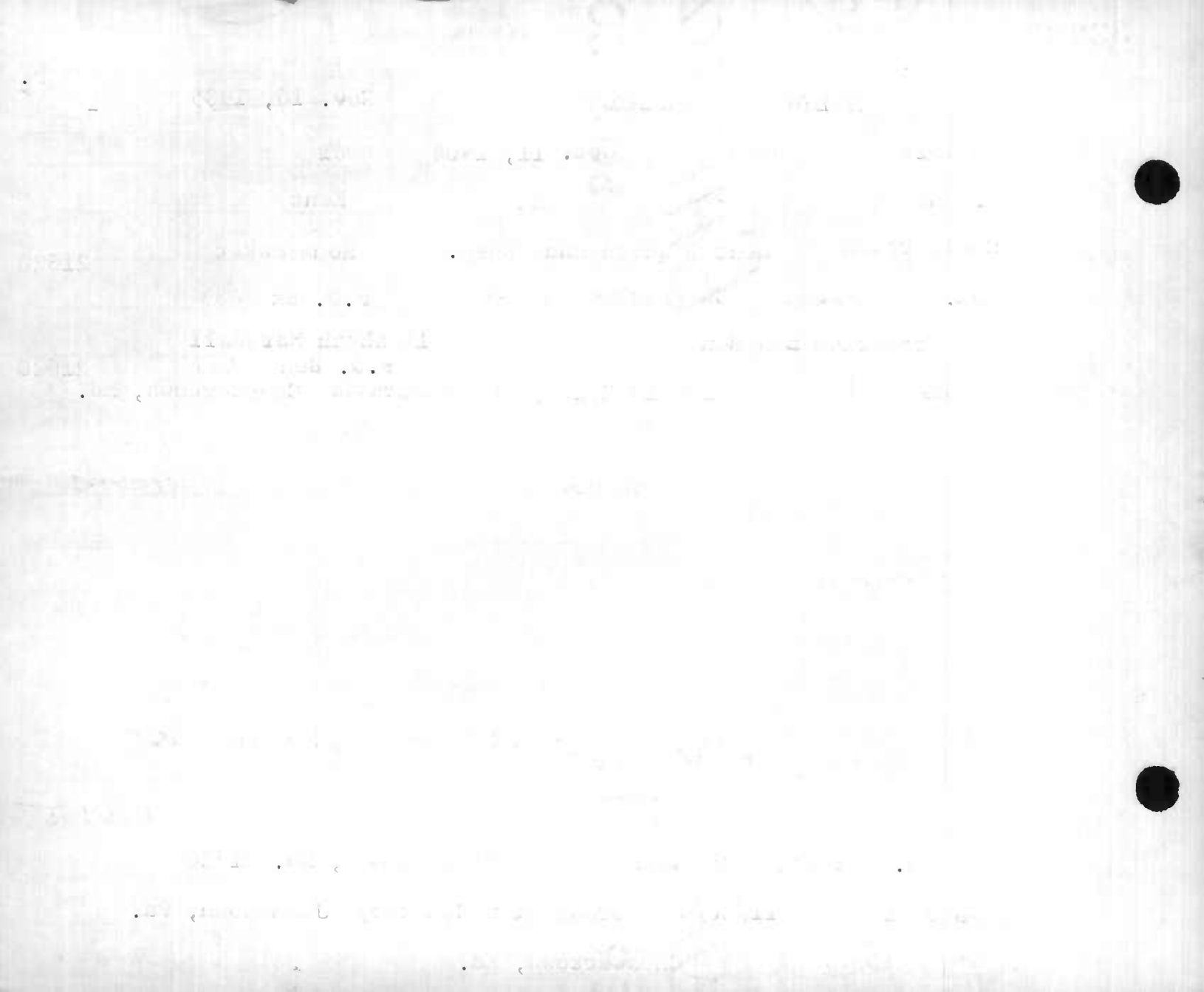
REG. NO.

|   |  |   |   |   |  |   |   |  |  |
|---|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EVELYN SIMMONS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 16, 1985</b>                   |   |  | 2b. HOUR P.<br><b>1 M</b>   |   |  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 11, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                     |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Kent</b> MD.                               |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chestertown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kent &amp; Queen Anne Hosp.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>21620</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Kent</b>  |   | 13c. CITY OR TOWN<br><b>Chestertown</b>                          |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>P.O. Bx 433</b>  |  |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Longdon</b>            |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Marshall</b>            |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>184 18 2010</b> |   | 17. INFORMANT<br><b>P.O. Box 433</b>                             |   |   | 17. ADDRESS<br><b>21620</b>  |  |
| 17. NAME<br><b>Harry Simmons</b>  |  |   | 17. CITY OR TOWN<br><b>Chestertown, Md.</b>                                   |   |  | 17. STATE<br><b>Md.</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>years</b><br>Approximate interval between onset and death<br><b>minutes</b>      |  |   |   |   |  |   |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>Emphysema</b> |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)        |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 19 80</b> , to <b>Nov 16 85</b> , that (I) (we) last saw the deceased alive on <b>11/14</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>C. Gottfried Baumann</b>   |  |   | DEGREE  |   |  | 22c. DATE SIGNED<br><b>11/18/85</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. Gottfried Baumann</b>  |  |   | 22e. ADDRESS<br><b>Chestertown, Md. 21620</b>                                 |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>11/20/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grand View Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Johnstown, Pa.</b>                             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. Willis Wells</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>Nov 21 1985</b>              |   |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |   |   |  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



337078

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH   |  |
| Female Sherri Ashley Teat  |  | Female  |  | White   |  | 11/27/85   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Kent Maryland  |  | Chestertown   |  | Kent  |  | Kent   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Chestertown  |  | Kent & Queen Anne Hospital  |  | none  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13b. STATE  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  |
| MD   |  | Queen Anne's  |  | Chestertown   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  |
| Gene Franklin Teat   |  | Jennifer Jones  |  | no  |  | none   |  |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) |  | 19. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| Gene F. Teat   |  | Cardiorespiratory Failure   |  | 11/27/85  |  | 11/27/85   |  |
| Chestertown, Md. 21620   |  | Encephalocoel and Meningomyeloel  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
|  |  | 2Hrs. 46Min   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
|  |  | 2Hrs. 46 Min  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)      |  | 21b. TIME OF INJURY  |  |
|  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 21d. INJURY OCCURRED   |  |
|  |  |   |  |   |  | 21e. PLACE OF INJURY   |  |
|  |  |   |  |   |  | 21f. LOCATION  |  |
|  |  |   |  |   |  | 22a. I certify that (I) (this hospital) attended the deceased from 11/27/85 to 11/27/85, that (I) (we) lost saw the deceased alive on 11/27/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
|  |  |   |  |   |  | 22b. SIGNATURE   |  |
|  |  |   |  |   |  | 22c. DATE SIGNED   |  |
|  |  |   |  |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |
|  |  |   |  |   |  | 22e. ADDRESS   |  |
|  |  |   |  |   |  | 23a. BURIAL, CREMATION, REMOVAL  |  |
|  |  |   |  |   |  | 23b. DATE  |  |
|  |  |   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
|  |  |   |  |   |  | 23d. LOCATION  |  |
|  |  |   |  |   |  | 24. FUNERAL DIRECTOR   |  |
|  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |
|  |  |   |  |   |  | 26. ADDRESS  |  |
|  |  |   |  |   |  | 27. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 28. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 29. ADDRESS  |  |
|  |  |   |  |   |  | 30. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 31. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 32. ADDRESS  |  |
|  |  |   |  |   |  | 33. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 34. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 35. ADDRESS  |  |
|  |  |   |  |   |  | 36. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 37. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 38. ADDRESS  |  |
|  |  |   |  |   |  | 39. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 40. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 41. ADDRESS  |  |
|  |  |   |  |   |  | 42. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 43. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 44. ADDRESS  |  |
|  |  |   |  |   |  | 45. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 46. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 47. ADDRESS  |  |
|  |  |   |  |   |  | 48. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 49. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 50. ADDRESS  |  |
|  |  |   |  |   |  | 51. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 52. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 53. ADDRESS  |  |
|  |  |   |  |   |  | 54. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 55. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 56. ADDRESS  |  |
|  |  |   |  |   |  | 57. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 58. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 59. ADDRESS  |  |
|  |  |   |  |   |  | 60. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 61. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 62. ADDRESS  |  |
|  |  |   |  |   |  | 63. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 64. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 65. ADDRESS  |  |
|  |  |   |  |   |  | 66. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 67. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 68. ADDRESS  |  |
|  |  |   |  |   |  | 69. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 70. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 71. ADDRESS  |  |
|  |  |   |  |   |  | 72. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 73. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 74. ADDRESS  |  |
|  |  |   |  |   |  | 75. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 76. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 77. ADDRESS  |  |
|  |  |   |  |   |  | 78. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 79. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 80. ADDRESS  |  |
|  |  |   |  |   |  | 81. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 82. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 83. ADDRESS  |  |
|  |  |   |  |   |  | 84. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 85. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 86. ADDRESS  |  |
|  |  |   |  |   |  | 87. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 88. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 89. ADDRESS  |  |
|  |  |   |  |   |  | 90. DATE REC'D. BY REGISTRAR   |  |
|  |  |   |  |   |  | 91. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |   |  | 92. ADDRESS  |  |
|  |  |   |  |   |  | 93. DATE REC'D. BY REGISTRAR   |  |
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|  |  |   |  |   |  | 104. ADDRESS   |  |
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|  |  |   |  |   |  | 113. ADDRESS   |  |
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|  |  |   |  |   |  | 116. ADDRESS   |  |
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|  |  |   |  |   |  | 203. ADDRESS   |  |
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|  |  |   |  |   |  | 233. ADDRESS   |  |
|  |  |   |  |   |  | 234. DATE REC'D. BY REGISTRAR  |  |
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339146

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 1 9 0 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William Golley Teat</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 22, 1985</b>                                    |   | 2b. HOUR<br><b>1:56 am</b>                                      |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>CAUC.</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG 6, 1998<sup>R</sup></b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Kent</b> MD.                     |   |
| 10. CITY OR TOWN OF DEATH<br><b>Chestertown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Kent &amp; Queen Anne's Hospital, Inc.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>FARMER</b>                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FARMING</b>                         |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br><b>MARYLAND Q.A.</b> |  | 13c. CITY OR TOWN<br><b>SUDLERSVILLE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>BOX 21 ROE RD. 21668</b>               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                        |  | 16b. SOCIAL SECURITY NO.<br><b>218-12-1552</b>   |   | 17. INFORMANT ADDRESS<br><b>JACK SHORT son RD1 Box 8L 11 Maryland 21649</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><i>Patrick Moloney</i>   |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><i>11/26/85</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICK MOLONEY MD</b>   |  | 22e. ADDRESS<br><b>MEDICAL OFFICE BLDG CHESTERTOWN, MD 21620</b>       |  |  |   |

|  |                              |   |   |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                    | 23b. DATE<br><b>11/25/85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BUSIC CEMETERY</b>                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BARKLEY, Q.A. MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FELLOWS F.H. BOX 270 MILLINGTON, MD 21659</b> |                              | 25. DATE RECEIVED BY REGISTRAR (BY REGISTRAR'S SIGNATURE)<br><i>John Davidson</i> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified.



33014



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR  
1- STATE  
REGISTRAR

312005

|  |         |  |  |   |  |                                   |  |                                       |  |                          |  |       |  |      |  |          |  |
|--|---------|--|--|---|--|-----------------------------------|--|---------------------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)          |         | FIRST  |  | MIDDLE  |  | LAST                              |  | 2a. DATE KNOWN OF DEATH               |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| AINO   |         | WALTER   |  |   |  |                                   |  | 11/2                                  |  | 19                       |  | 85    |  | 7:45 |  | P        |  |
| 3. SEX                                       | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                    |  | IF UNDER 24 HRS.                      |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| Female                                       | white   | 2/6/88   |  | 97  |  | YRS.                              |  |                                       |  | 11/2/1985                |  | 19    |  | 85   |  | 7:45     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)    |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH- |  |                          |  |       |  |      |  |          |  |
| Finland                                      |         | USA  |  | WIDOWED   |  | DIVORCED                          |  | Kent                                  |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH                    |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                                       |  |                          |  |       |  |      |  |          |  |
| Chestertown                                  |         | Kent & Queen Anne Hosp.                                  |  | Homemaker   |  |                                   |  |                                       |  |                          |  |       |  |      |  |          |  |
| 13a. STATE                                   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS                   |  |                          |  |       |  |      |  |          |  |
| Md.  |         | Kent   |  | Chestertown   |  | YES                               |  | Rd # 2 Box 327                        |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME                            |         | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |                                   |  |                                       |  |                          |  |       |  |      |  |          |  |
| David  |         | Elizabeth  |  |   |  |                                   |  |                                       |  |                          |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | Rd # 2 Box 327                    |  | Otso Walter Chestertown, Md.          |  | 21620                    |  |       |  |      |  |          |  |
| no   |         | 212 74 8471  |  |   |  |                                   |  |                                       |  |                          |  |       |  |      |  |          |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>                                       |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| (b) <u>8809</u>  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| (c)  |  |  |  |

|   |  |   |  |
|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |   |  |
| <u>Laceration to scalp from fall</u>  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |
|   |  |   |  |
| 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |
|   |  | 6:54 P.M. 11-2 19 85  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |  |
| Fall down steps   |  | Home  |  |
| 21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                           |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                             |  |
|   |  | Rt. 2 Box 327, Chestertown, Kent, Maryland                          |  |

|   |  |                     |  |
|---|--|---------------------|--|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |  | TITLE (SPECIFY)     |  |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .                            |  | Deputy              |  |
| ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.   |  | MEDICAL EXAMINER    |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | DATE SIGNED 11-4-85 |  |
| Robert W. Farr  |  |                     |  |

|   |  |                               |  |                                    |  |   |  |
|---|--|-------------------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) |  | 23b. DATE                     |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |
| Burial                                    |  | 11/5/85                       |  | Chester Cemetry                    |  | Chestertown, Md.                        |  |
| 24. FUNERAL DIRECTOR                      |  | 25a. DATE REC'D. BY REGISTRAR |  | 25b. REGISTRAR'S SIGNATURE         |  |   |  |
| J. Wells Wells                            |  | NOV 07 1985                   |  | John Davidson-Randall              |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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